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ABSTRACT

A review of the literature and a survey of texts show a remarkable absence of concern and reference to depression and suicidal behavior in young children. The meaning of death, the depressive and suicidal consequences of the agony of aloneness, and the fear of parental hostility, rage and abandonment are elements of early and middle childhood living denied recognition by parents and professionals alike. Only a few researchers, mostly in recent years, have paid attention to these problems. This paper reviews this research with particular reference to findings related to depression and suicide in young children. First, childhood depression is discussed in terms of its symptoms and types, related factors (such as relationships with parents, caregivers, and peers), and treatment. Second, the nature of suicide in young children, factors which may underlie suicidal behavior in young children (such as family dynamics, rejection by the peer group, and school performance), the child's concept of death, and patterns of discovery and treatment are considered. (Author/MP)

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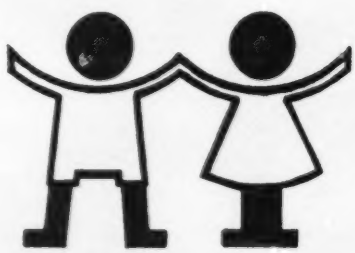

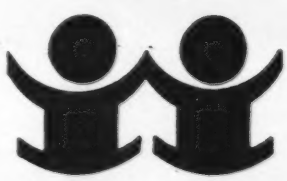

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DISABLING EMOTION IN YOUNG CHILDREN WITH PARTICULAR REFERENCE TO DEPRESSION AND SUICIDE

An Overview of Current Research

SHELLEY PHILLIPS

DISABLING EMOTION IN YOUNG CHILDREN

WITH PARTICULAR REFERENCE TO

DEPRESSION AND SUICIDE

An Overview of Current Research

Dr Shelley Phillips *University of New South Wales*

INTRODUCTION

Disability is usually associated with physical disability for which there is an underlying sympathy in the community. But what of other kinds of disability and, in particular, emotional disability? Emotional disturbance can be a disabling obstacle to healthy growth, yet the community is not as sympathetically disposed towards the emotionally disabled child as it is toward the physically disabled. Typically, there is anger and irritation toward the child who plays up in school, throws repeated tantrums in public places, or cannot relate to others. Obsessed with the concept of "normal adjustment", whatever that is, we cast the emotionally disabled child out.

But what is it like to be an emotionally disabled child? In endeavouring to generate insight into some aspects of the question I shall confine myself to consideration of two little understood areas in early childhood: depression and suicide. I do this because our society generally does not associate these things with young children. We romanticise childhood in our society, and, in doing so, increase the suffering of the emotionally disabled child because we refuse to recognise the disability or to understand it.

Review of the literature and a survey of texts show a remarkable absence of concern and reference to depression and suicidal behaviour in young children, although there is a mass of it in reference to adolescence and adulthood. An apparent taboo exists against awareness and recognition of self inflicted injuries and depression in children before adolescence (Paulson & Stone, 1974). The meaning of death, the depressive and suicidal consequences of the agony of aloneness, and the fear of parental hostility, rage and abandonment are elements of early and middle childhood living denied recognition by parents and professionals alike. Fortunately, there are a few researchers who have paid attention to these problems, mostly in recent years, and, in this paper, I shall discuss some of their findings.

First, I shall consider childhood depression, its description, its symptoms, and what we, in the community, can do about it. Secondly, I shall consider suicide in young children.

PART I

CHILDHOOD DEPRESSION

According to a report in the Sun Herald on August 3rd, 1980, Dr Joaquin Purgentich, a doctor from New York State Psychiatric Institution, has described victims of childhood depression as one of the most discriminated against and misunderstood minorities in the western world. His claim is widely supported in the research and should inspire those who care for children and can empathise with them to be alert to the depth and meaning of childhood depression, for its presence and symptoms are as painful and as disastrous to the infant, toddler or primary school child as they are to the adult or adolescent.

SYMPTOMS AT DIFFERENT DEVELOPMENTAL AGES

1) Infancy

We are all familiar with the early work by Bowlby and Spitz on the extremely depressed state of infants without maternal affection in the stark orphanages of the 40s. The term "anaclictic depression" was coined by Spitz (1945) to describe a condition of misery, crying, withdrawal and failure to survive in babies and young children deprived of maternal love. This research indicated that many such infants either die or grow into emotionally and intellectually disabled adults; it has more recently been criticised for failing to note that these children were not only deprived of mothers, but also fathers and general environmental stimulation (Phillips, 1980a); nevertheless the work was a valuable introduction to the possibility of infantile depression and has been continued. It is now believed that non institutionalised infants may suffer depression and that this may be evidenced in continued eating and sleep disturbances, colic, crying, and head banging (Gore, 1976).

2) Early and Middle Childhood (2-10 years)

As the child grows older, symptoms of depression may be withdrawal, apathy, regression, tempter tantrums, continued disobedience, truancy, running away from home, or masochism, as indicated by the child who is self destructive and manages to get beaten up by other children. The youngster is concerned that he or she is bad, evil, unacceptable. Such feelings lead to anti social behaviour which attracts retaliation. This further reinforces and verifies the feeling of badness. Since the youngster often feels inferior to other children, he or she tends to act out behaviours which confirm such feelings.

Additional symptoms of depression have been suggested in the work of Melanie Klein (1948) who was more prepared than many in her time to recognise childhood depression. She directed much of her attention to the child's fantasy life which she saw as an important part of development; for her, childhood neurosis is a repression of fantasy due to the load of guilt and depression which affect many aspects of the child's life. The depression may appear as sleep disturbances (difficulty in getting to sleep, early waking, nightmares and night terrors), problems of feeding and elimination, and also in the inhibition of intellectual and emotional life. There may be either maladjustment or over adjustment to educational requirements, an inability to learn, play or be creative, and an intolerance of frustration (Gore, 1976).

DEFINITION ACCORDING TO SYMPTOMS

According to Kovacs and Beck (1977) and Lefkowitz and Tesing (1980) the following depressive symptoms are most often agreed upon:

1. The child's mood is sad or unhappy. There is irritability and weepiness and a reduction in the capacity for pleasureable experience.

2. There is low self esteem, self deprecation, loneliness - perhaps thoughts of suicide, morbid ideas, recent poor school performance and disturbed concentration.

3. The child's motivation is decreased and there is diminished psychomotor activity, social withdrawal or increased aggressiveness.

4. Also apparent are fatigue, sleep problems, enuresis or encropesis, weight loss, or anorexia and somatic complaints (stomach pains and headaches in particular).

In summary, depression can be most disabling, with a sense of despair and hopelessness that is worse than physical pain.

VIEWPOINTS ON THE MANIFESTATION OF CHILDHOOD DEPRESSION

1) No Symptoms

The most predominant viewpoint is that it is rare and that it doesn't appear until late childhood and adolescence. In the light of recent research this viewpoint is unfounded.

2) Symptoms Similar to Adults

This viewpoint argues that, except for some development-specific modifications, childhood depression resembles adult depression - as defined above. Generally, most contemporary research appears to support this view.

3) Symptoms are Masked

This alternative view suggests that most children do not express depression directly, and that it must be inferred from behaviours and symptoms "masking" the underlying depressive feelings (Gore, 1976). They include conduct disorders (hyperactivity, delinquency, aggressiveness, irritability), and psychological reactions (such as stealing in a rejected child), psychosomatic illnesses, hypochondria, somatic complaints (especially headaches and stomach aches), enuresis, school problems, or poor school performance. These kinds of symptoms often appear in children whose histories reveal exaggerated stubbornness and negativism (known as the passive aggressive personality structure), and where family members show disorganisation and, in some cases, psychopathy.

Research by Carlson, and Cantwell (1980) suggests that, although these account for most child psychiatric referrals, it is unlikely that depression is behind all of them. In fact, in their research, they found that some children with feeding disturbances (anorexia nervosa) and behaviour disorders did not seem depressed at all. However, in many cases of children with anorexia nervosa, attention deficient disorders (hyperactivity) and conduct disorders (aggressive and antisocial behaviour) a depressive disorder co-exists. Often the behaviour is so outstanding that it overshadows the depression and diverts attention away

from the concomitant depression. To an alert clinician, conducting a thorough interview, the depression will not be masked. Methods of identification will be discussed later.

GENERAL CLASSIFICATIONS

Those who accept that children may suffer depression define three types according to severity.

1) Acute Depressive Reactions

These usually occur following a traumatic event in children who are usually well adjusted - for example, following the death of a caregiver or during and after divorce of the parents (Gore, 1976). There is persistent sad affect, feelings of hopelessness, social withdrawal, retardation, sleep and eating disturbances. Details of children's depressive reactions during divorce are discussed in the paper *Current Issues in Maternal and Paternal Deprivation* (Phillips, 1980a) and, as indicated in that paper, it seems important in this condition to give the child time to mourn and plenty of loving support.

2) Chronic Depressive Reactions

These appear in children with a marginal and precarious adjustment who may have had depressive episodes previously, probably resulting from separations dating from early infancy, the clinical features of which are similar to the acute types. The child may be prone to weep, lack interest in things, be unable to concentrate, despondent about the future, and generally low in spirits. The usual sleep difficulties of depression are present and they may take the form of difficulty in getting to sleep, restless and disturbed sleep, or wakening early in the morning. Similarly, there is reduced appetite, complaints of abdominal pain, and so on. However, the chronically depressed child is excessively clinging and dependent. There is usually a history of depressive illness in the family and there may be a seesaw depression between mother and child (Gore, 1976). The chronically depressed child is also more likely to become hostile, rebellious and antisocial, or frankly delinquent behaviour may develop. Such children may express the desire to be dead, or run away - which they may actually do - for in children, running away from home may be motivated in a way similar to some adult suicidal attempts.

This condition is typically labelled in psychiatric circles as neurotic rather than psychotic because the child's concept of reality is not disordered. One wonders about the legitimacy of the description neurotic. In fact, many children with so-called "neurotic" depressive conditions are found to be facing considerable environmental stress, most often due to tensions or disturbances in the family, and the child's depressive reactions are understandable as a coping device. The child may have to cope with psychotic or neurotic illness in one or other parent, or the child may find himself or herself unable to meet the parent's desires and expectations (for example, academically at school). Physical illness in any member of the family (including the child) may play a part. The threat of the loss of a parent is particularly likely to cause anxiety or depression in the child. Disharmony between the parents has a similar effect. These circumstances do not necessarily cause depression, but are likely where there has been chronic longstanding stress as mentioned above (Barker, 1976). Bowlby has argued for a willingness to accept that mourning or sadness may be a realistic rather than neurotic reaction to such situations. The case of Tom is an example:

Tom was aged 9 when first brought for treatment. His mother, with paranoid schizophrenic tendencies, who had been abused and abandoned by her own mother in infancy, threatened to commit suicide from time to time. Frequently she used suicidal threats as a means of punishing Tom just as she had been punished by the departure of her own mother.

As is often the case in such cases of abandonment, the mother's trust in affectional relationships had been undermined in infancy and she,without warrant,generalised and saw ill will toward her and threat of loss of love in Tom who had come to represent her abandoning parent. Such role reversals are not unusual, and Tom collected the ambivalent loving and hostile attitudes which the mother had toward her own parent. Tom had lived on a razor edge of anxiety with his mother for all of his 9 years, and had been constantly criticised, and constantly subjected to wild outbursts of rage intermingled with unpredictable love and affection.

Tom felt so unhappy that he ran away hoping to make his way to family friends in Melbourne. His IQ was found to be high, 130, yet his school performance was but average and well below his capabilities; his self esteem was poor. Fortunately for Tom, he was ultimately sent, by recommendation of the psychologist, to a boarding school and his symptoms of depression diminished. As an adult he regularly visits his mother - each visited post-dated by two days of depression (Unpublished case notes).

3) Psychotic Depression

When the depression can be understood in terms of the stress the child is facing, a diagnosis of psychosis is not appropriate. Psychosis is generally diagnosed when the child "is out of touch with reality and the mood (or affect) is markedly deviant from normal" (Barker, 1976). Psychotic depression is said to be more common after puberty than before it (Barker, 1976) but new research is throwing doubt on this old belief. Not infrequently one comes across young children so crippled by guilt that reality has lost its meaning, as in the following case:

Jan, aged 9, felt guilt whenever anyone in her circle became ill or had a misfortune. Her mother had always blamed Jan's naughty behaviour for her headaches, her chills for Jan's carelessness or selfishness in expecting that she attend school sports or festive days in blustery weather, and her anxiety on Jan's imagined silent criticism of her. Jan had understandably incorporated these constant criticisms into her concept of self and was now unrealistically seeing herself as responsible for general misfortunes. (Unpublished case notes)

In psychotic depression there is sometimes slowing of thought and speech and also of motor activities (psychomotor retardation). Refusal to go to school may be one of the earliest symptoms to occur, the ordinary stresses of school being more than the depressed child can cope with.

FACTORS RELATED TO CHILDHOOD DEPRESSION

1) Infant Caretaker Relationships

Many studies including those by Klaus & Kennell (1970) and Brazilton (1962) point to the consequence of mother/infant separation in the parinatal period. They suggest that absence of bonding and attachment may lead to a life-long inability to establish relationships of basic trust with either caregivers, siblings, peers or significant others. This crippling disability may first be evidenced in childhood through emotional detachment or "frozen" personality patterns, isolation, withdrawal, serious depression and, at times, suicidal

tendencies. Unfortunately, there is little organised research on the effects of father absence or limited father involvement in child rearing and nurturance, although clinical reports suggest that it is important in individual cases.

2) Relationships with Parents

Once more, unfortunately, the research on toddlers and middle childhood has paid very little attention to the role of the father and placed undue burden on the mother (Phillips, 1979, p 147-151). However, much more recent research suggests that where there is a disturbed relationship with either or both parents the child may become depressed (Phillips, 1980, Part II, pp 2-4). Schrut (1964) points out that, where the basic feeling directed toward the child is one of him or her being a burden, albeit unconsciously, and is evidenced from infancy, depression is likely. Moreover, self aggression in the form of depression is a partial fulfillment of the parent's unspoken demands that he or she be punished for existing.

3) Disruption in Development of Self Concept

Continual, unrelenting and highly negative appraisals (Phillips, 1979, Ch 5) can induce poor self esteem in children and this, as has been suggested, may be the setting for depression. In the process of self concept development, caretakers also tend to set up the goals of an ideal self for the child which include ways of being a "good" child, pleasing others, achieving well, and so on. Children strive to achieve these goals and, in supportive families during early childhood, they may, from time to time, believe that they are their ideal self and boast that they are "good" or clever. This is part of healthy self concept development. Beyond 7 or 8 years of age the development of the thought processes gradually enable children to begin to see themselves in a more objective fashion. If an ideal self has been set at unreachable heights by caretakers and significant others, children may become depressed at being unable to equate the real self with it.

4) School

The school environment can be a crucial factor in childhood depression. Five or six year old children often regard their teacher with awe, and for the eight or nine year old he or she can still be an important source of ideas, standards and self esteem, because teachers, like parents, may be accepting or rejecting in their attitudes towards children. School attainment may also figure in depression as in the case of the dull child who cannot keep up with his or her class and becomes anxious or unhappy or the child with a particular educational problem, such as a reading disability, especially if it is not recognised or understood. Occasionally, difficulties also arise as a result of a child being much brighter than his or her schoolmates.

5) Peers and Neighbourhood

Rejection by peers, or poor relationships with school mates can figure significantly in childhood depression, as can cultural isolation in a school or neighbourhood where most belong to a culture which is different from the child's own. There are many other factors in childhood depression but, as much of what is later discussed as relevant to suicidal behaviour can also apply to depression in children, I shall, at this stage, turn to ways and means of identifying depression in childhood.

Carlson and Cantwell's work (1980) suggests that traditional evaluation procedures can overlook depression in children in 60% of cases and that when children are interviewed systematically about their symptoms, a much higher incidence of depressive disorder is found. They used an introductory, unstructured, rapport setting situation, a questionnaire based on vegetative, cognitive and psychomotor behaviour and a structured interview which examined the child's view of his or her problems, peer, family and school relationships, physical symptoms, anxiety, and obsessional, delusional, anti-social symptoms and behaviours. There was also a systematic interview with parents and a check on peer relationships. With these systematic procedures, as in other research of this nature, a much higher incidence of depressive disorders is found than by usual evaluation procedures. They, as other researchers do, conclude that it is possible to diagnose children over age 7 as having a major depressive disorder using adult research diagnostic criteria.

It is also to be noted that the research of Carlson, and Cantwell showed that more girls than boys suffer depression; this represents a cultural trend, since girls tend to show more affective disorders than boys due to a socialisation process in our culture which encourages girls to develop emotional and caring responses (Phillips, 1980, Part II, p 1). However, it is interesting that Ashenback (1978) found a syndrome of depression in his recent investigation of the behaviour problems of boys aged six to eleven. He did not find such a syndrome in his earlier work (1966) and he suggests that cultural changes may be leading to a greater incidence of depression in boys.

Lefkowitz and Tesing (1980) believe that peers are most helpful in identifying depression in children. They asked almost 1,000 fourth and fifth grade children to nominate children who had a number of characteristics which experts felt defined depression in behavioural terms as follows:

Question	Identification item
Who are you?	D
Who often plays alone?	D
Who thinks they are bad?	D
Who doesn't try again when they lose?	D
Who often sleeps in class?	D
Who often looks lonely?	D
Who often says they don't feel well?	D
Who says they can't do things?	D
Who often cries?	D
Who often looks happy?	H
Who likes to do a lot of things?	H
Who worries a lot?	D
Who doesn't play?	D
Who often smiles?	H
Who doesn't take part in things?	D
Who doesn't have much fun?	D
Who is often cheerful?	H
Who thinks others don't like them?	D
Who often looks sad?	D
Who would you like to sit next to in class?	P
Who are the children you would like to have for your best friends?	P

(D = Depression; H = Happy; P = Popularity)

They found that the peer assessment, the children's assessment of themselves, and the teacher's assessment correlated and by these means they were able to identify depressed children. They also found that the potential intellectual performance of the depressed children was reduced; they were unpopular and had low self esteem and viewed events in their environment as externally controlled (Phillips, 1979, pp 155-6); they were absent from school significantly more often than were children less frequently nominated and tended to come from low income families. These authors feel that symptoms of childhood depression can be translated into observable behaviours and can be reliably and validly assessed by a peer nomination technique.

TREATMENT

1) Education of the Community

If one wishes to alleviate the lot of severely depressed children, the first most important step is recognition in the community that depression in children can, and does, occur and that the child suffers like all human beings in this disabling condition. Education in this area is much needed and should include parents, child care workers, teachers, doctors, paediatricians, psychiatrists and other professionals who work with children. Apart from this fundamental procedure, the most commonly recognised methods of treatment include removal of the causes, psychotherapy and family therapy.

2) Removal of Causes

Where the condition is a reaction to stress this should be removed or modified. For example, in the case of some children who are severely depressed by the prevailing atmosphere in their school, parents have been known to move to another area with a more favourable school; or in another example, support for a depressed mother may improve her condition and that of her depressed child. Similarly, well chosen foster placements or boarding school may help alleviate a child's stressful home conditions. Education about childhood depression for all those involved with the child is again indicated.

3) Psychotherapy

The child may benefit from psychotherapy.

4) Family Therapy

In many cases the causes of depression lies in the family, and an approach by family group therapy is required.

(a) Scapegoating

When a child is depressed, it is often helpful to look at the structure and functioning of the family group as a whole, as well as the relationship between individual members. When this is done the behaviour of the depressed child can sometimes be seen as meeting the needs of the whole family. For example, a family feeling inferior in a particular neighbourhood or inadequate, may relieve themselves of guilt or responsibility by nominating, albeit unconsciously, one sibling to portray behaviours which are said to be the root of the family's troubles with the neighbours or other children. Thus, one sibling may begin to steal frequently, or expose him or herself at school, and, in this way, the family may unconsciously encourage and invest their feelings of badness in the

child, building it into his or her self concept. Such children may develop a hopeless sense of being denied an independent self, bewildered by behaviours which are theirs but not theirs, and become depressed.

(b) Reversal of Roles

Reversal of roles can be another form of scapegoating. The child is obliged to substitute for a perhaps neglecting or inadequate parent in the parent's own childhood and expected to make up for past inadequacies but at the same time expected to fail as the parent did. A child in such a double bind is in a sorrowful position and understandably, may become depressed. In the same category one meets the little old man or little old lady child who takes no pleasure in childish things and who is fulfilling the parental role demanded of him or her by parents who cannot fill this role adequately themselves. Such children often feel imprisoned, powerless, and angry about a role which is not of their own making but are bewildered by their own part in it and the extent of their responsibility. Cases of school phobia (Phillips, 1980a) often exist where there is reversal of roles. The parent needs the child at home as a caretaker, yet it is the child who is treated as the problem. This is another double bind type of situation which is often the setting for childhood depression.

(c) Diversion

It sometimes seems that delinquent behaviour in a child is diverting attention from a marital problem: the child unconsciously feels that he or she is obliged to behave badly so that the parent's anger is directed towards him or her rather than towards each other. By behaving badly the child can keep the family together (Barker, 1976, p 25), but the manoeuvre often takes its toll in the depression which accompanies it.

DEPRESSION AND NORMALCY

One of the problems about recent research into childhood depression is the assumption that it is always pathological and that "normal" children do not suffer it. Charles Costello (1980) believes depression is as typical of childhood as it is of adulthood and argues against this assumption and also the common belief that childhood depression is inevitable at certain developmental stages. Thus, for example, lack of appetite at 6 (37% in girls and 29% in boys in a study reported by Costello, 1980) is dismissed as "usual" and, therefore, not significant. Lapousse (1966) in her study of 6 - 12 year old children concluded that symptoms of depression occur in 20 - 40% of normal children. Other, and later studies. support this. Aggressiveness, hyperactivity, crying, sleep disturbances, psychosomatic disturbance, hypochondriasis, delinquency, temper tantrums, disobedience, truancy, restlessness, are symptoms that encompass all children at one time or another. Of course, it is well recognised that, although a particular problem may occur with high frequency in normal children of a certain age, it may occur with significantly higher frequency among children who have a number of behaviour problems. Thus, Richman (1977) found poor appetite in 14.6% of her 4-year-old normal children and 39.6% of problem children of the same age; nocturnal enuris occurred in 17.7% of normal children and in 30.2% of the problem children.

1) Should We Disregard Developmentally "Normal" Depression?

There is a general presumption that clinical intervention is only justified

when a problem persists. If a symptom such as head banging in infancy and poor appetite at six say, is fairly common, it is seen as a developmental trend and the tendency is for paediatricians to become concerned about this only if it persists at nine when it is not so usual. This attitude is akin to the tolerance of child abuse in our society and an aspect of the tendency to incorrectly regard children as unduly resilient and inhumanly carefree. It may be more humane to argue that, although a depressive problem is developmentally usual or lasts only a short time, we would do well to try and shorten or prevent that behaviour because *(a)* it makes life more bearable during childhood and *(b)* it may have some bearing on later disturbances in more vulnerable children.

For instance, fears in a particular situation may characterise a certain age group and may eventually disappear, but during that critical period some vulnerable children may develop conditioned fear responses to other situations. Costello (1980) feels, and I agree with him, that it is important that we do not become too nonchalant about problem behaviours in children no matter how prevalent or transitory they may be. The occurrance of some particular problem behaviour in childhood may increase the probability of adult disorder in some individuals even when it is not labelled as abnormal by anyone, because it is prevalent and disappears with increasing age. Above all, while the problem is around, it is disrupting childhood and a source of unhappy emotional disability to the child.

Much more research is needed to assess whether the depressions, typical of different developmental ages in our culture are typical of other cultures or a result of prevailing trends in our child rearing practices. Perhaps our way of life loads children with too much guilt; or maybe the confines of the nuclear family are unduly demanding of the child's developing emotional interactions. It certainly seems that the undue isolation and responsibility thrust on mothers in the nuclear family can contribute to their depression which is then shared with their children. Often, giving support to the mother in such a case removes or diminishes the child's depression.

The factors considered previously, as related to childhood depression, need to be watched carefully in any family or school. The provision of sustained affectional relationships, plenty of security and praise to build a strong self concept (Maron, 1979; Fahey, 1980), removal of anxiety-making pressures to succeed in sports, compete or meet unrealistic expectations and encouragement of good friends of the child's own age, are some of the positive measures to discourage chronic depression. If the child does become acutely depressed, due to the death of a pet or beloved grandparent, or separation from a beloved caretaker, then time to mourn with plenty of support can be a preventive measure against chronic depression. Like adults, children may be depressed by small setbacks, such as a temporary argument with a friend or a missed opportunity and, like adults, they need sympathy and support instead of brush off remarks such as "boys don't cry" or "smarten up now".

As we have seen, infants are also susceptible to pressures, tensions, and lack of affection, for they are vulnerable learners and perceivers from the moment of birth (Fein, 1979). The issue of day care is one of many sensitive areas and I mention it because of late, the media has portrayed many minding centres where the infants are listless and depressed. Every precaution should be taken to ensure that the day care centre suits the needs of the infant, and that the caregiver is an affectionate and consistent person to whom the infant responds well, and that there is sufficient stimulation and freedom for the activities the infant needs to develop (Fein, 1979). Frequent change of daycare centres, where the quality of care is good, should also be avoided as infants can become depressed by removal from familiar caretakers.

In summary: depression is experienced by young children and infants. Let us ensure that they are not permanently disabled by it.

PART II

SUICIDE IN YOUNG CHILDREN

WHY IS THE EVIDENCE SUPPRESSED?

Adult and adolescent suicide as an expression of internalised hate and unconscious death wishes to others is well understood. However, a review of the literature and a survey of recent texts on child development show a remarkable absence of concern and reference to suicidal behaviour in young children. As stated earlier, there seems, until very recently, to have been a taboo against awareness and recognition. Why is this?

One possible explanation is the need in our society to romanticise childhood as a time of lighthearted innocence and selfishness. It takes a mature society to empathise fully with children and to recognise the sorrows and injustices of childhood. To relieve guilt we romanticise the period. Yet most of us remember little of our own childhood.

Another factor is the tendency to deny death in our society. The researcher's, the parent's or the teacher's inability to cope with their own anxiety and ambivalent ideas about life and death may, in part, influence and hamper their ability to deal with suicidal behaviour in children (Pfeffer, 1979). This inability may mean also that the child's suicidal symptoms are not recognised, or research in the area is not undertaken or is prevented by authorities.

The unfounded traditional belief in some psychiatric and medical circles that young children do not attempt suicide has also been influential. This belief appears to stem from psychoanalytic theory. For example, Rocklin (1965) believes that depression involves the superego, which is not fully developed in children. Similarly, some practioners assert that children are unable to plan and effect a suicide attempt because of lack of size, strength, motor coordination and ability to obtain needed materials. This outdated view reflects a lack of developmental understanding about children which is, unfortunately, all too common in our society.

Recent research establishes the incorrectness of these theories and the necessity for continuing education to update outworn and unsubstantiated beliefs. For example, Pfeffer and associates (1980) reported that at least 33% of 30 children randomly selected for evaluation in an outpatient psychiatric clinic at a large municipal hospital centre in New York City contemplated, threatened and/or attempted suicide. She believes that this increased incidence of suicidal children seeking psychiatric evaluation may reflect not only an increase in suicidal behaviour among children, but also the results of more thorough clinical evaluations (1981).

THE NATURE OF SUICIDE IN YOUNG CHILDREN

The nature and style of suicides and attempted suicides in young children can range from the pathetically bizarre to violent self mutilation. Some use fire as a means of self immolation, others attempt stabbing with knives or scissors, or throwing themselves from heights. One 8-year-old girl threw herself from an upper apartment window onto a spiked iron railing to escape re-

peated sexual molestation by her father.

Many of these attempts arise out of a long history of family disturbances and depression, or are a product of especially difficult cultural, economic and developmental demands. For example, boys are most at risk for suicide attempts during the ages 7-11 years (Paulson, Stone & Sposto, 1978). For boys, these years appear to be the time when interpersonal pressure and inner feelings of despair are apparently at their peak. It may well be that this is because there is increased pressure to assume masculine characteristics and suppress emotionality and femininity at this age (Phillips, 1979, Ch 3; Phillips, 1980a, Part II p 1).

Suicidal behaviour in girls is almost evenly distributed through the age range of 4 to 12 years. There is no sex difference in young children in self violence and mutilation. Hanging, stabbing, cutting, scalding, burning, purposeful running into moving vehicles, self destruction by fire, and jumping from high buildings far exceed the few non-violent attempts to die by over medication.

The reason for this could be that children's self distinction is modelled on violence in the family or the planning of a drug-induced death is more difficult for a young child to execute; even at the adult level it is exceedingly difficult to kill oneself by drug ingestion. Nevertheless, self poisoning as a means of suicide appears to be on the increase.

1) Poisoning

A number of studies (Paulson, Stone & Sposto, 1978; The National Clearinghouse for Poison Control Centres, 1968; McIntire & Angle, 1970; Sobel, 1970; Teicher, 1970; Springthorpe et al, 1977) have found that an increasing number of children under age 12 are being admitted to poison centres and/or emergency hospitals for accidents and "accidental overdoses". These studies suggest that self poisoning of a child over six is rarely accidental. The ingestion of drugs and poisons, and the many accidental injuries may be purposeful, self destructive acts on the part of the child, whose depression driven behaviour is a result of parental psychopathology and family chaos (Paulson, Stone & Sposto, 1978). These studies emphasise the need for heightened awareness among practitioners who may examine children who are over five for accidental poisoning.

2) Traffic Accidents

It is especially important to carefully investigate children who suffer repeated accidents and children "accidentally" injured by running into a moving vehicle. Husband and Hinton (1972) and Plionis (1977), in studying families of such accidentally injured children, noted a high incidence of psychosomatic illnesses, family stress and other psychosocial factors which must be explored before concluding that a child is "accident prone".

3) Unrecognised Suicides

Numerous children's deaths reported as accidents may be unrecognised suicides, and what appears to be an accident may be a manifestation of a child's failing method of coping. Sensitising and educating clinicians to the types of skills needed to assess the psychological factors prominent in a child's accidental behaviour or accident proneness would promote prevention and intervention (Pfeffer, 1981).

FACTORS WHICH MAY UNDERLIE SUICIDAL BEHAVIOUR IN YOUNG CHILDREN

The major causal factors of suicidal behaviour in young children are thought to be impaired parent/child relationships as in items *1a* to *1e*.

1. *Family Dynamics*

a) *Personal social dynamics.* Families which are isolated, are emotionally detached or neglectful and insensitive to the affectional needs of others (Paulson & Stone, 1974), have a higher proportion of suicidal children.

b) *Family disharmony.* Continual and distressing conflict together with isolation also encourages suicidal wishes in young children (Paulson et al, 1974, 1975).

c) *Failures in infant-child/mother bonding and personal attachment between family members.* Where these are missing or there are multiple placements in foster homes, or rejection by step parents and step siblings, children tend to become despairing and depressed and may become suicidal (Shaffer, 1974; Renshaw, 1974; Spitz, 1945; Bowlby, 1969). Constancy of care and affection by at least one familiar figure appears essential for developing infants and children, otherwise they become self destructive, hostile to all potential caregivers and unable to form attachments. The following case is illustrative.

A nine-year-old boy, chronically rejected by his mother, expressed a wish to kill himself; his mother, sister and grandmother, each of whom was seen as a non-nurturing rejecting female.

Crook and Raskin (1975), Alexandrowicz (1976), Wallerstein and Kelly (1976) state, however, that early separation of parent and child does not in itself predispose the child to attempt suicide - marital discord and pathological family interaction, identity diffusion, emotional disorganisation, severe depression, added to separation make the difference.

d) *Abandonment.* Depression and suicidal attempts have also been seen as a cry for help where extended hostility between the parents is leading to separation or divorce. Such children often become depressed and guilty that they have caused the rift (Phillips, 1980a). Most inducive of depression can be a child's fear of abandonment by the remaining parent of a single parent family.

e) *Acute sibling jealousy.* While sibling rivalry is an aspect of most nuclear families, acute jealously leading to suicidal behaviour is not. The latter generally reflects family and parental insensitivity to the affectional needs of others and insufficient understanding of the development of children.

2. *Rejection by the Peer Group*

Rejection by the peer group as well as parent and siblings, can create for a child, a disabling world of social isolation, emptiness and emotional starvation. Fantasies of monsters, fears of being killed by burglars, nightmares of panic and fear are often typical of such children and reflect their aloneness (Paulson & Stone, 1974).

3. *School Performance*

A child's inexplicable and seriously deteriorating school performance may be an index of suicidal depression, especially where there is a history of severe family discord and parental conflict (Paulson, Stone & Sposto, 1978).

4. *Idiosyncracies*

However, while stressing the importance of the family and school milieu, many researchers stress the importance of also considering the idiosyncracies of the child as one factor in understanding self destructive behaviour (Chess, Thomas & Birch, 1967). Some children are more vulnerable than others.

5. *Family Violence*

a) *Modelling.* There is a significant association between chaotic family disorganisation and the self violence of the child. In some families, reported in the research, violent conflict by means of knives, razors and guns was common, as was severe wife beating. In addition, sometimes suicidal children may have a family history of suicidal behaviour. The severely depressed child acts out and models himself or herself on the family violence and the wish to die is a pathetic plea for love and affection by a rejected and isolated child in such families; in addition, since the young child is still developing a self concept (Phillips, 1979, Chapter 5), the rejection by significant others is incorporated into the self view and becomes one of violence and destructive self loathing.

b) *Atonement and relief.* In some children this internalised hate and anger, and the masochistic self destructive acts of violence, become so intertwined with the feelings of guilt and blame heaped upon them by significant others, that atonement and relief seems possible only by escape into a suicidal state of separation from the family relationship (Paulson, Stone & Sposto, 1978).

> "If I kill myself there won't be any more fighting. I'm going to kill myself and everyone in the world. Who cares if I kill myself." (seven-year-old boy who, at age six, tried to stab himself with a butcher's knife.) (Paulson & Stone, 1974).

> "I want to go to heaven. I can't stand these stomach aches and being unhappy ... living is horrible. I just want to die because nobody cares if I die; so I just want to die. I'm ugly and a failure." (eleven-year-old boy - severely depressed by constant fighting and arguing of parents.) (Paulson & Stone, 1974)

c) *Fear.* For many older children, the witnessing of family violence both verbal and physical, precipitates acute panic, fear and concern that they might by the next victim of violent assault. While one 8-year-old girl in Paulson, Stone and Sposto's study said "They don't like me, I wish I was dead", another said 'I would rather die than be spanked."

d) *Generalisation.* These children are often violent to others as well as themselves.

> One seven-year-old boy who had stated "Mother doesn't have any love in her heart for me" tried to suffocate his 18-month-old

brother with a pillow, tried to kill a pet dog and then stabbed pins and needles into his own stomach (Paulson & Stone, 1974).

6. The Wish to Join Loved Caregivers and Significant Providers

Research indicates that some children, particularly if they come from violent homes, may attempt suicide in the belief that this way they can join a deceased and beloved grandmother or other relation to decrease loneliness or find someone who had cared for them.

One boy found hanging out of a 4th floor window wanted to escape an intolerable home and join Santa Claus (Paulson, Stone & Sposto, 1978).

It is often the hope and expectation of children that in death they will find the pleasures missing from their daily lives and the ideally loving, nurturant and giving mother (Ackerley, 1967).

7. Manipulating Guilt and Punishing Overly Neglecting or Punitive Parents

Motivations leading to childhood suicidal behaviour include conscious and unconscious fantasies, wishes, fears and prohibitions. Bender and Schilder (1937) long ago suggested that latency-age children may react to an unbearable situation such as deprivation of love with aggressive tendencies that are directed against those who deny love. Under the influence of guilt and with a wish to escape, the child also turns his or her aggressive tendencies against the self. Thus, motivation for suicide may be an attempt to punish a severely punitive or neglecting parent.

"When my father hits me I want to die. One day I shall die and he'll come to my grave and be sorry." (8-year-old boy, unpublished case notes)

8. A Cry For Help

The attempted suicide may be a plea to remedy a stressful situation. Psychoanalytic researchers (Ackerley, 1967), in a study of latency age suicidal children, suggest that ego development can be so disrupted by stress and anxiety that regression to a chatoic state or decomposition of the ego takes place. The accompanying psychosis and discordered, nightmarish, bewildering thoughts drives the child to a suicidal attempt.

Reinterpreted in self theory terms, one might say that the development of the self concept (Phillips, 1979, Ch 5) is damaged during the developmental process by the child taking into his or her self concept the guilt, accusations, and rejections by the significant others in his or her world. The conflict between the child's self recognitions, ideal self and ugly portrayals of himself or herself by others leads to confusion and disintegration of what may have already been achieved in self concept development. To gain relief from this terrifying and bewildering process the child may try to suicide.

THE CHILD'S CONCEPT OF DEATH

Suicide attempts are sometimes based on the child's view of death. I have discussed the latter elsewhere (Phillips, 1980a). To over summarise for the purposes of this paper, the research suggests that until the age of five (6 or 7 in some cases), the child considers death as temporary, rather like sleep or a journey, and that not only is coming to life again possible, but that it may also be seen as a rebirth with the possibility of making all past wrongs and sorrows right. One case quoted in my paper (1980b) illustrates this point:

> A 7-year old boy whose parents were estranged and who was regularly beaten by the defacto husband of the mother, lay down on a busy highway. He told the policeman that he wanted to die - then Dad would come back and they would all live together again.

Other researchers suggest that suicidal latency age children have distinct concepts that death is a temporary and pleasant state (Pfeffer, Conte, Plutchik et al, 1979). These researchers note that such beliefs may facilitate suicide, especially among children with psychopathology and children under severe stress.

Between the ages of five and nine the child may personify death. Thus, some children with suicidal fantasies may suffer severe nightmares about a burglar or bogeyman who tries to kill them. Generally, after the age of nine, children begin to recognise death as irreversible and learn that it inevitably applies to them as well as everyone else. Nevertheless, suicidal children of this age, and later, may still tend to believe that death is not final (McIntire, Angle & Strumpfer, 1972).

PRESENT PATTERNS OF DISCOVERY AND TREATMENT

Paulson, Stone & Sposto's study (1978) indicates that most of the identified suicidal children come to the attention of social service organisations which have shown concern about the parent's capacity to nurture adequately and care for their children. The next two most frequent referral sources are private doctors and hospital paediatric clinics, suggesting that parents are aware of the turmoil in their child's mind. Unfortunately, there sometimes remains the problem of the adequacy of medical staff to recognise the urgency of the child's situation. For many children, referral to a medical practitioner for organic complaints, psycho-physiological and psychosomatic symptoms are the first recognised sign of emotional distress. Once again the basic problem of disabling depression and suicidal wishes are not always recognised by the medical practitioner in such cases.

The detective and supportive role of community services, teachers, child care workers, medical practitioners or the public, cannot be minimised. People in the front line of work with children must be educated and become alert to the concomitant conditions and symptoms that may put a child at risk of depressive and suicidal behaviour.

Treatment is similar to that indicated in depressed children. They may require intensive therapy, including family therapy, school consultations, and academic remediation. Rapid intervention is necessary because follow-up studies indicate that the greatest risk for completed suicide is two years after the first attempt (Otto, 1972).

The more recent stress on cognitive factors in depression and suicide (Kovacs & Beck, 1977) appears to represent an advance in both our view of, and respect for, children and gives a better comprehension of childhood depression, despair and suicide. The child's view of himself or herself, the world, and the future must be carefully evaluated with reference especially to such interacting variables as family pathology, peer pressure, school expectations and socioeconomic pressures. Knowing these elements, we may better understand why an increasing number of young children find their day-to-day living so emotionally painful, and so lacking in care and support that they elect to die rather than to live (Paulson, Stone & Sposto, 1978).

Paulson, Stone and Sposto's study reports that, with well-chosen foster placements or sensitive counselling, many children will respond favourably in an

environment of warmth, affection and acceptance in spite of the absence of close attachments in their early life and in spite of a wish to die because they were unloved. The criterion for a successful therapeutic process, whether it be in the natural family, a foster home, or an institution, is the establishment of caring, supporting and encouraging relationships with one person. There needs to be love with the appropriate limit setting. In addition, in many cases therapeutic support enables many young mothers, overwhelmed by every imaginable pressure to function better in the parenting role. Unfortunately, improving the role of fathers is still not receiving sufficient attention.

CONCLUSION

Depression and suicide are a reality for young children. Overloaded by guilt, isolated by aloneness, and threats of violence, repressing unacceptable feelings of anger and rage are too much for many to bear. Death is less painful than the despair of living. These are emotionally disabled children, robbed of the capacity to function by circumstances beyond their control. We must educate ourselves and others, be alert to all possible symptoms, and know how and where to secure effective and sensitive intervention. Only then can we give help to those emotionally disabled children who are presently without hope and recognition in our neighbourhood, our schools and our clinics.

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Unpublished Case Notes. Case notes denoted in this way are the author's, all names are fictitious.